300 – Pharmacy Services Program

Pharmacy Name: _____

Pharmacy Address: _____

Confirmation / Provider #: _____

Provider payee # (if available): _____

☐ Change of Ownership OR ☐ Initial Application

The following information and/or documentation are required to complete the application for enrollment in the Pharmacy program:

_____ Provider Enrollment Application
Must have the original signature of the authorized representative of the applicant

_____ Statement of Participation
Must have the original signature of the authorized representative of the applicant

_____ IRS Form W-9
The payee name on the W-9 must match the business name as registered with the IRS.

_____ 147-C letter, tax coupon or other documentation from the IRS that reflects the legal name and Federal Employer Identification number of the business.

_____ Power of Attorney
If the designated payee is different from the applicant, a signed and notarized Power of Attorney for Payee must be completed..

_____ National Provider Identifier (NPI)

_____ Electronic Funds Transfer Agreement

_____ Copy of Pharmacy license issued by the state's Board of Pharmacy

_____ National Council for Prescription Drug Program (NCPDP) number.
NOTE: NCPDP Dispenser Class and Type of (7) not eligible for Pharmacy enrollment.

_____ Copy of Drug Enforcement Administration Certificate

_____ Georgia Medicaid Disclosure of Ownership and Control Interest Statement form (or a copy of the documents filed with Medicare)

Comments: _____

_____

_____

Return application and documentation to:

ACS, Provider Enrollment Unit
Post Office Box 4000
McRae, Georgia 31055-4000
1-800-766-4456

GA DEPT OF COMMUNITY HEALTH, DIVISION OF MEDICAL ASSISTANCE

Pharmacy Provider Enrollment Application Instructions

A. Applicant Base Information:

1a. Enter the pharmacy's business name. The "legal business name" is required. The "doing business as" name is optional.

Facility Type valid values:

0	Government	1	Non-Profit or Religious	2	Sole Proprietorship
3	Investor-Owned	4	Public	5	Private – For Profit
6	Private – Not for Profit	7	Not Applicable	9	Other

1b. Indicate whether or not this organization operates any other sites, locations, or units. Also indicate where those operations are.

B. Address Information:

1. The Service Location (Physical) Address is required for all providers. This is the street address from where you intend to provide services to Medicaid and/or PeachCare for Kids members. **Post office boxes are not allowed**.
2. The Mailing Address is optional. Use this field if you receive postal mail at an address other than the physical address provided above. Post office boxes are allowed. If this information is not applicable for your practice, please indicate by marking the "N/A" checkbox.
3. The Pay-to Address is the address where you would like remittance advices, and other payment information, sent. This address is obtained from the W-9 form that you are required to submit.
4. The Office Manager's information is required in order to obtain access to view information on the Web Portal.

C. Program Enrollment Information:

Does this pharmacy participate in the 340B program? *(If you have any questions regarding this program, please call the HRSA Pharmacy Services Support Center, 800-628-6297.)*

Enter the Georgia Medicaid Payee # assigned to your Federal Employer Identification #. Your company will not have this number if this is your first time enrolling with GA Medicaid.

Pharmacy Class Code Valid Values:
A - Retail Chain Pharmacy; H - Hospital Pharmacy; L - Long Term Care Pharmacy; R - Retail Pharmacy; C - Clinic Pharmacy

A National Provider Identifier number (NPI) is REQUIRED for ALL Pharmacies. If you do not have an NPI number, please visit the National Plan and Provider Enumeration System at https://nppes.cms.hhs.gov/NPPES/Welcome.do **to request one**.

D. Provider Medicare participation information.

Your Medicare information **must** be on file if you wish to receive Medicare/Medicaid crossover payments.

E. Other Medicaid Programs

Provide information regarding participation in other state's Medicaid programs, past and/or present. If this information is not applicable for your pharmacy, please indicate by marking the "N/A" checkbox.

F. Provider Credentials

1. License: Please enter the license information for the state in which the pharmacy is located.

G. Languages: Indicate any languages that are spoken at the pharmacy. Place a check in the box next to the primary language.

BA	Bangla	CC	Cambodian/Campuchean	CH	Chinese (Mandarin)
CZ	Czech	EN	English	FA	Farsi
FP	Filipino	FR	French	GE	German
HI	Hindi	IN	Indian	IT	Italian
JA	Japanese	KO	Korean	LA	Laotian
NA	Navajo	PO	Portuguese	RU	Russian
SA	Slavic	SL	American Sign Language	SP	Spanish
SW	Swahili	TA	Taiwanese	TU	Turkish
VN	Vietnamese	ZZ	Other		

H. Other Information:

Correspondence Medium:

a. Receiving letters (including rosters, if applicable) by paper is ONLY available to applicants who are not capable of receiving information in an electronic format.

b. Receiving bulletins by paper is ONLY available to applicants who are not capable of receiving information in an electronic format.

c. Receiving remittance advices by paper is ONLY available to applicants who are not capable of receiving information in an electronic format. The x12-835 option requires that you have a contract with a clearinghouse.

d. WINSAP requires special software, which is available through the EDS Billing Office. For more information, call (800)766-4456.

Applicant History: this section is for exclusion and/or sanction information. Please provide accurate information regarding previous and current exclusions and sanctions.

I. Certification & Signature: Facility applications should be signed by the owner of the business or an agent authorized who has the authority to bind the pharmacy to a legal contract.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH, DIVISION OF MEDICAL ASSISTANCE
PHARMACY PROVIDER ENROLLMENT APPLICATION

A. Applicant Base Information	Departmental Use Only:

1a. Pharmacy			
Legal Business Name:			Tax ID:
"Doing Business As" Name:			
Type of Facility:(see instructions for list of valid values)		State Where Incorporated:	
1b. Does this organization operate other sites, locations, or units? ☐ NO ☐ YES		If YES, where?	

B. Address Information

1. Service Location (Physical) Address

Street Address: (PO Box NOT Acceptable)			Suite:
City:	County:	State:	Zip +4:
Office Phone:	Office Fax:	Office Email: (if available)	
After-Hours Phone:	Office Website: (if available)		
Is this location open 24 hours? ☐ Yes ☐ No	Is this location TDD/TTY equipped? ☐ Yes ☐ No		

2. Mailing Address - (if different from Physical Address) ☐ **N/A**

Name of Practice: (if applicable)			
Street Address/ PO Box:			Suite:
City:	County:	State:	Zip +4:
Phone:	Fax:	Email: (if available)	
After-Hours Phone:	Website: (if available)		

3. Pay-to Address - The Pay-to Address should be placed on the W-9 Form

4. Office Manager Information

Name: (Last)	First:		MI:
Email:	SSN:	DOB:	
POA ID#: (if available)			

C. Program Enrollment Information | GA Medicaid Payee #:

a. Contract Code: 300	Specialty Code: 198/199	Provider Type: 180	Pharmacy NPI:
b. Is the pharmacy a 340B entity? ☐ Yes; ☐ No	Existing GA MCD Payee Provider #: ☐ N/A	Drug Store Type: ☐ Proprietary (For Profit) ☐ Non-Proprietary (Non-Profit)	Taxonomy Code (Primary):
Chain Code:	Pharmacy Class Code:	NCPDP #: *(Note: NCPDP Dispenser Class and Type (7) not eligible enrollment)*	Taxonomy Code (Secondary):

D. Medicare Information ***(Required if the pharmacy will receive Medicare/Medicaid crossover payments)***

b. Medicare Provider #: ☐ N/A	Effective Date:	End Date:

E. Other Medicaid Programs ☐ **N/A**

a. Medicaid ID:	State:	Current Status: ☐ Active ☐ Inactive	
Type of Service:	Effective Date:	End Date:	
End Date Reason:			

b. Medicaid ID:	State:	Current Status: ☐ Active ☐ Inactive	
Type of Service:	Effective Date:	End Date:	
End Date Reason:			
c. Medicaid ID:	State:	Current Status: ☐ Active ☐ Inactive	
Type of Service:	Effective Date:	End Date:	
End Date Reason:			

F. Provider Credentials

License(s) – attach a copy of the current pharmacy license

a. License #:	License Board:		
License Type:	Issuing State:	Effective Date:	End Date:
b. License #:	License Board:		
License Type:	Issuing State:	Effective Date:	End Date:

DEA Information: *attach a copy of the current DEA certification*	Certification #:	All Schedules? ☐ Yes ☐ No (2, 2N, 3, 3N, 4, 5)

G. Languages – List all languages spoken at this Facility. (see Instructions for valid code values)

Primary:	2.	3.
4.	5.	6.

H. Other Information

a. Letter Medium	☐ Email ☐ Fax ☐ Paper ☐ Web Portal Message Center
b. Bulletin Medium	☐ Paper ☐ Web Portal Message Center
c. Remit Medium	☐ Paper ☐ Web Portal Message Center ☐ X-12-835 via Clearinghouse
d. Billing Medium	☐ Paper ☐ Batch ☐ Web Portal Claims Submission ☐ POS ☐ WINSAP*/Dial-Up

Applicant History (use additional sheets if necessary)

a. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency?	☐ No ☐ Yes
If YES, please explain:	
b. Has the applicant ever been placed in prepayment review status by Georgia Medicaid?	☐ No ☐ Yes
If YES, please explain:	
c. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or been excluded from any Federal of State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?	☐ No ☐ Yes
If YES, furnish name and relationship of family/household member(s):	
d. Has the applicant or any member of the practice been involved in malpractice litigation in the past ten (10) years?	☐ No ☐ Yes
If YES, please explain the disposition of the case:	

e. Has the applicant's practice ever had a recoupment of more than $5,000 in any 18-month period?	☐No ☐Yes
If YES, please explain the recoupment:	

I. Certification & Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification; omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read Part I, Policies and Procedures for Medicaid/Peachcare for Kids Providers and Pat II, Pharmacy Services manuals), herein and I authorize Medicaid or its authorized representative to verify this information.

Printed Name of Applicant or an Authorized Agent	
Signature of Applicant or an Authorized Agent	Date: